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PROGNOSIS FOR ACUTE SITUATIONAL MALADJUSTMENT DISORDERS/TRANSIE--ETC(U)
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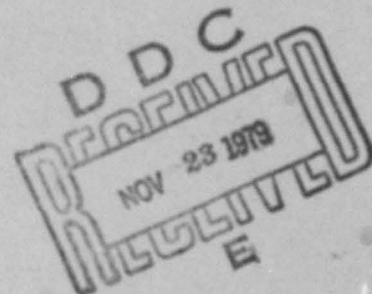
PROGNOSIS FOR ACUTE SITUATIONAL MALADJUSTMENT DISORDERS/TRANSIENT
SITUATIONAL DISTURBANCES: DIAGNOSTIC VALIDITY AND PROGNOSTIC INDICATORS*

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Prognosis for Acute Situational Maladjustment
Disorders/Transient Situational Disturbances:
Diagnostic Validity and Prognostic Indicators

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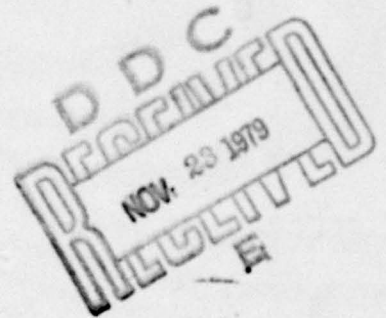
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Prognosis for Acute Situational Maladjustment
Disorders/Transient Situational Disturbances:
Diagnostic Validity and Prognostic Indicators*

Wynne (10), reviewing the history of criteria for defining Acute Situational Maladjustment, noted that during World War II influential psychiatrists called attention to large numbers of patients suffering from acute situational disturbances and neither institutional nor psychoanalytic treatment concepts and procedures seemed appropriate for these disorders. As a result the 1952 Diagnostic and Statistical Manual: Mental Disorders (DSM-I) introduced new nosological categories of "gross stress reaction" ("reactions to deal with overwhelming fear") and "adult situational reaction" ("superficial maladjustment to a difficult situation").

The diagnostic criteria remained essentially the same in the 1968 revision of the Diagnostic and Statistical Manual (DSM-II), but this class of disorders was designated Transient Situational Disturbances and was defined as follows:

This major category is reserved for more or less transient disorders of any severity (including those of psychotic proportions) that occur in individuals without any apparent underlying mental disorders and represent an acute reaction to overwhelming environmental stress If the patient has good adaptive capacity his symptoms usually recede as

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Abstract

Disposition decisions and post-hospital outcomes were studied in a large sample of male Navy psychiatric patients diagnosed Acute Situational Maladjustment. Of the total sample 90 per cent were returned to naval duty after relatively short periods of hospitalization. A substantial number of readmissions (27 per cent) and other forms of adjustment failure (15 per cent) indicated that diagnostic criteria need to be improved and valid prognostic indicators identified. Almost one-half of the cases rehospitalized were diagnosed Character and Behavior Disorder, suggesting that these underlying personality disturbances were undetected during the first hospitalization.

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the stress diminishes. If, however, the symptoms persist after the stress is removed, the diagnosis of another mental disorder is indicated.

Clearly, the diagnosis of Acute Situational Maladjustment is based primarily upon recognition of a precipitating event and a favorable prognosis rather than specific symptomatology or etiology.

Wynne (10) states that "lacking adequate research, psychiatrists still do not know how many or what kinds of acute situational disturbances turn into chronic psychiatric or medical illnesses or contribute to other disabling but undiagnosed problems of living" (p. 1609). Feinstein (4) presented evidence that crisis reactions and psychiatric illness both can be present and influence one another.

These disorders seem particularly prevalent in youth and in old age, periods of life involving many situational and developmental changes. With regards to adolescents, Masterson (8), after conducting a long-term study, concluded that the tendency to attribute symptomatology among adolescents to temporary, developmental turmoil rather than to psychiatric illness may dangerously delay the therapeutic intervention required to prevent the development of more serious psychopathology. Also, Gallemore et al (5) indicated that adolescent turmoil frequently overlays significant affective disorders and that these disorders are often unrecognized and untreated because of assumptions about developmental characteristics of adolescents. The recent insightful study by Offer and Offer (9) shows that periods of situational turmoil are not part of the process of normal development from adolescence to young manhood.

Method

Subjects were 2,078 male Navy enlisted personnel discharged from naval medical facilities with diagnoses of Acute Situational Maladjustment during calendar years 1966-1969. Diagnoses for the sample were established with reference to the Department of Defense Disease and Injury Codes, July 1963, and are comparable to those specified in the American Psychiatric Association Diagnostic and Statistical Manual: Mental Disorders (DSM-I). Subcategories included were Adult Situational Reaction, Gross Stress Reaction, Acute Situational Reaction NEC, and Transient Stress Reaction. Combat Exhaustion cases were not included in the study.

For cases with more than one admission during the period of study, data from the first admission were utilized for predictive purposes. For cases in which transfers from one hospital to another occurred, data recorded from the last hospital were used. Outcome studies could only be conducted on patients returned to duty; a major phase of the study involved 1,874 patients returned to duty after hospitalization. The composition of the Return to Duty (RTD) and Non-Return to Duty (NRTD) subsamples in terms of demographic and clinical characteristics is shown in Table 1. The racial distribution for the total sample was the same as that for the Navy enlisted population. The average score on the General Classification Test (GCT), a verbal aptitude test, was only slightly below that for the Navy generally.

Data Collection

Individual records of psychiatric hospitalizations for Navy and Marine Corps personnel are sent to the Bureau of Medicine and Surgery Data Services

Intense stresses may be encountered in military life and precipitate significant adjustment problems. Accurate diagnosis of these disorders is important in the military milieu because of the presence of more serious pathology, if undetected and untreated, may result in prolonged inefficiency or invalidism, rehospitalization, and discharge from service. Valid hospital dispositional decisions are particularly important because of a substantial proportion of patients given this diagnosis are experienced, career-oriented personnel with skills much needed by the naval service.

Individuals suffering acute situational maladjustment disorders in civilian life are frequently seen by mental health workers in hospital emergency rooms, university student health centers, and community mental health facilities -- usually on an outpatient basis. In the U.S. Navy, partly because of the remoteness of many naval ships and stations from outpatient psychiatric facilities, a larger proportion of these patients are hospitalized. Although many cases are seen in both military and civilian treatment settings, no large-scale studies have been conducted of prognosis or diagnostic validity of this group of patients. Because of standardized record-keeping and ease of follow-up for very large groups of patients after treatment, such evaluations can be effectively carried out in the naval setting (6).

Diagnosis presumably is the most important consideration in determining disposition decisions, but other information concerning the patient's clinical and military history has been found relevant to the evaluation of adjustment potential (1,2,3). In this study the relationships of demographic, military history, and clinical characteristics to disposition from the hospital and to post-hospital adjustment are examined in the total population of Navy enlisted Acute Situational Maladjustment patients during a four-year period. Consistency of diagnosis for a sample of rehospitalized cases is determined as a check on the validity of the original diagnosis.

Center, Bethesda, Maryland, by Naval Regional Medical Centers. The records contain the following information: age, years of service, pay grade (rank), sex, race, marital status, occupational specialty, duty assignment, admitting facility, hospital transfers, length of hospitalization, primary and secondary diagnoses, existence of condition prior to entry into service, and disposition from the hospital. Copies of these records are forwarded to the Naval Health Research Center, San Diego, where they are extensively edited and stored for use in epidemiological and clinical research.

Criterion data pertaining to success or failure after return to duty were obtained from two sources: Bureau of Medicine and Surgery inpatient psychiatric files provided rehospitalization data and Bureau of Naval Personnel computer tapes provided information as to date and type of discharge from service and recommendation for reenlistment. Effectiveness was defined as completion of at least six months on active duty after hospitalization and, if separated from service after six months, completion of current enlistment with a favorable discharge and a positive recommendation for reenlistment; rehospitalization for a psychiatric condition or receiving an unfavorable discharge (such as Unsuitability or Bad Conduct) or a negative recommendation with respect to reenlistment determined ineffectiveness.

Diagnoses received during second hospitalizations were examined in a random sample of 20 per cent of those rehospitalized to determine consistency of diagnosis from first to second hospitalization.

In addition, narrative descriptions of clinical history, precipitating factors, and symptomatology were obtained for a randomly selected sample of 35 patients in order to determine types of crisis events typically associated

with initial hospitalization.

Procedure

The first phase of the analysis was concerned with identifying factors related to decisions to return men to duty. The total sample was divided into those returned to duty (RTD) and those not Returned to duty (NRTD) as determined by follow-up information contained in the Bureau of Naval Personnel computer tapes. The RTD and NRTD groups were compared on a number of demographic, clinical, and outcome characteristics, and correlations were computed between relevant variables and the dichotomous criterion RTD versus NRTD.

In the second phase of the analysis outcome (effectiveness rate) was determined for those returned to duty and variables were identified that correlated with post-hospital effectiveness. In the third phase diagnoses of patients readmitted to the hospital were examined to compare original diagnoses with rehospitalization diagnoses. Finally, clinical records were reviewed to identify typical precipitating factors.

Results

Results pertaining to disposition decisions (returned to duty versus separation from service) and post-hospital effectiveness are considered separately.

Disposition Decisions

The RTD and NRTD groups are compared on selected variables in Table 1. The RTD group was older, had longer service, and had achieved higher pay

grades on the average than the NRTD group. The RTD group also had shorter hospitalizations than the NRTD group.

Correlations of predictor variables with disposition decisions and post-hospital effectiveness are shown in Table 2. Eleven variables were significantly correlated with RTD decisions ($p < .05$). Pay grade, job specialty, duty station, length of service, and age were most highly correlated with return to duty.

Two other variables, marital status (married) and number of diagnoses (absence of secondary diagnosis), also correlated positively with return to duty at a high level of significance ($p < .001$).

Men in higher pay grades and in certain technical job specialties, for example, Radioman and Electrician's Mate, were more likely to be returned to duty than others. Also, men admitted to hospitals from certain types of specialized duty assignments, for example, submarines and Underwater demolition Teams, were more likely to be returned to duty. Again, these types of duty assignments require higher levels of ability and training than other duty assignments.

Post-Hospital Effectiveness

The effectiveness rate for patients returned to duty was 58 per cent overall: 36 per cent of the men in the RTD sample completed their enlistments and were recommended for reenlistment; 19 per cent continued on active duty to the end of the follow-up period; 2 per cent received medical discharges unrelated to their psychiatric conditions, and a small number of individuals (less than 1 per cent) died during the follow-up period.

Rehospitalization was the major type of failure after return to duty (27 per cent); 19 per cent of the men were prematurely discharged for administrative reasons, and 5 per cent were discharged and not recommended for reenlistment at the end of their enlistments.

In Table 2 it can be seen that certain variables that correlated most highly with RTD decisions also correlated most highly with post-hospital effectiveness. These variables were: pay grade, job specialty, duty station, length of service, and age. Job specialty was a complex variable reflecting both differences in pay grade and differences in technical skills and training. Pay grade as a single variable had the highest correlations with both return to duty and post-hospital effectiveness.

The presence of secondary psychiatric diagnoses, in addition to the primary diagnosis of Acute Situational Maladjustment, was negatively correlated with return to duty decisions but did not correlate with effectiveness. Presumably the presence of secondary diagnoses indicates uncertainty that the true diagnosis is Acute Situational Maladjustment or the possibility of more severe psychopathology. Either of these alternatives might be expected to have unfavorable prognostic implications.

Assignment to limited duty status also correlated significantly with effectiveness. Limited duty refers to restrictions placed on a man's work assignment when he is considered temporarily unable to cope with the demands of an unrestricted work assignment; usually this means a shore assignment rather than sea duty. Patients assigned to limited duty subsequent to first hospitalization performed less well (44 per cent effective) than patients

returned to full duty (59 per cent effective).

Because a rather large proportion of men returned to duty were not effective (42 per cent), it seems evident that disposition decisions were often inappropriate. The major reason for ineffectiveness was rehospitalization (27 per cent of all RTD cases). The subsequent histories of a random sample of these rehospitalized cases (20 per cent of the total) were examined to determine the consistency of diagnoses from first to second hospitalization. The largest group of readmitted cases (47 per cent) was discharged from their second admissions with Personality Disorder diagnoses. Only 21 per cent of those readmitted received Acute Situational Maladjustment diagnoses; 23 per cent were diagnosed Neurotic Disorders, and 7 per cent Psychotic Disorders. Thus, a substantial number of patients returned to duty with Acute Situational Maladjustment diagnoses -- almost one-half of those subsequently rehospitalized -- probably had significant underlying personality disorder problems at the time of their first admissions. Relatively few patients were rehospitalized with psychoses, but one-half of the psychotic readmissions occurred within five to eight days after release from the first hospitalization, suggesting the presence of serious psychopathology in these patients during the first hospitalization.

Hospital clinical records were examined in a sample of 35 patients drawn randomly from one large naval hospital in order to determine situational factors associated with admission. Seven patients were admitted as a result of suicide attempts, and five admissions involved problems with alcohol. In the majority of cases (19 patients) conflicts with wives or girl friends were

reported as precipitating events. Job related problems were noted in 14 cases. These crisis events were not mutually exclusive; that is, both marital conflict and a suicide attempt were possible for the same patient. It seems clear that marital (or pre-marital) friction was the most common precipitating factor in these Acute Situational Maladjustment cases followed by tensions in the work situation.

Discussion

Diagnoses of Acute Situational Maladjustment are validated primarily by hospital course and post-hospital outcome. If the patient recovers rapidly after being removed from the precipitating stress, the diagnosis is considered correct. If the individual does not improve, it is assumed that more severe underlying pathology existed and a different diagnosis should have been assigned. However, some variability in outcome as a function of therapy is implied for the subcategory Adult Situational Reaction: "If untreated or not relieved such reactions may, in some instances, progress into typical psychoneurotic reactions or personality disorders" (DSM-I, p. 41). No guidance is offered for differentiating such cases from those that will recover promptly, however.

The principal goals of the present study were to examine disposition decisions and post-treatment outcomes in a large sample of Acute Situational Maladjustment patients in order to evaluate the consistency of treatment outcomes with the original diagnosis and to identify factors predictive of post-hospital adjustment in this type of disorder. Because of the diversity of medical facilities involved, ranging from small dispensaries with no psychi-

atric services to large hospitals with many experienced mental health professionals, some variability in diagnostic and disposition procedures would be expected despite generally standardized administrative and clinical practices. The fact that 90 per cent of all Situational Maladjustment cases were returned to duty after relatively short periods of hospitalization indicated that prognosis was rather uniformly regarded as very favorable for patients in this diagnostic category. The major problem revealed by the present analysis was the lack of accurate identification of underlying personality disorder pathology when it existed. The risk of subsequent psychosis in this population was low, but a few cases diagnosed Acute Situational Maladjustment may have manifested prodromal symptoms of schizophrenia during first hospitalization.

The post-hospital effectiveness rate for Acute Situational Maladjustment cases, while high compared with the other major diagnostic categories was not as high as would be expected from the definition of the disorder as given in the DSM-II. The substantial number of readmissions and other forms of adjustment failure (42 per cent ineffective) after return to duty indicates that diagnostic criteria need to be more clearly defined and valid prognostic indicators identified.

This study confirmed the prognostic importance of a number of variables reported in previous studies (1,2,3). The individual's past successful adjustment in his military occupation, reflected primarily by pay grade, consistently has been an important indicator of future adjustment. Other aspects of the individual's job assignment prior to hospitalization, that is, job specialty and duty station -- presumably reflecting technical skills and

training -- were significant factors in prognosis. Specific characteristics of the post-hospital military environment that might affect outcome were not examined but should receive future study. Job stresses may significantly affect the onset and course of physical or mental illness, but the effects of such influences are poorly understood at present.

In contrast to positive effects noted in a previous study which was concerned with all diagnostic categories (7), assignment to limited duty status was associated with a relatively unfavorable prognosis in this study. This type of disposition decision apparently reflects a guarded prognosis. The possible anticipated benefits of this form of extended therapeutic support were not realized in this population.

Because of the expectation of rapid, spontaneous recovery in this type of disorder, it does not seem surprising that less attention may be given to details of the clinical picture needed for treatment planning than in other types of disorders. According to Wynne (10) the ambiguity of the DSM-I and DSM-II guidelines concerning diagnostic criteria for Acute Situational Maladjustment/Transient Situational Disturbances "appears to be a manifestation of a more general uncertainty in psychiatry about whether and how to give explicit diagnostic attention to situational and contextual factors that affect prognosis and treatment outcome" (p. 1611).

The amount of clinical information considered in this study was limited. Further follow-up studies which include detailed clinical descriptions and differentiate patients with favorable and unfavorable outcomes should lead to improved diagnostic and prognostic criteria.

References

1. Berry, N. H., Edwards, D., Iorio, V., and Gunderson, E. K. E. A study of Navy and Marine Corps personnel admitted to the psychiatric sick list. Report No. 72-1. Navy Medical Neuropsychiatric Research Unit, San Diego, California 92152, 1972.
2. Berry, N. H. and Edwards, D. Actuarial odds scores for return to duty success of Navy and Marine Corps personnel admitted to the psychiatric sick list. Report No. 72-2. Navy Medical Neuropsychiatric Research Unit, San Diego, California 92152, 1972.
3. Clum, G. A. and Hoiberg, A. L. Biographical variables and post-hospitalization adjustment of psychiatric patients in the naval service. *Milit. Med.*, 135:177-181, 1970.
4. Feinstein, S. C. Adjustment reaction of adolescence. In Freedman, A. M., Kaplan, H. I., and Sadock, B. J., Eds. Comprehensive Textbook of Psychiatry/II, pp. 2094-2100. Williams and Wilkins, Baltimore, 1975.
5. Gallemore, J. L. and Wilson, W. P. Adolescent maladjustment or affective disorder? *Am. J. Psychiatry*, 129:608-612, 1972.
6. Gunderson, E. K. E. Epidemiology and prognosis of psychiatric disorders in the naval service. In Spielberger, C. E., Ed. Current Topics in Clinical and Community Psychology, Vol. 3, pp. 179-210. Academic Press, Inc., New York, 1971.
7. Iorio, V. A., Edwards, D., Berry, N. H., and Gunderson, E. K. E. Occupational support as a therapeutic tool. *J. Occup. Med.*, 14:860-861, 1972.

8. Masterson, J. F. The psychiatric significance of adolescent turmoil.
Am. J. Psychiatry, 124:1549-1554, 1968.
9. Offer, D. and Offer, J. B. From Teenage to Young Manhood. Basic Books,
Inc., New York, 1975.
10. Wynne, L. Adjustment reaction of adult life. In Freedman, A. M.,
Kaplan, H. I., and Sadock, B. J., Eds. Comprehensive Textbook of
Psychiatry/11, pp. 1609-1618. Williams and Wilkins, Baltimore, 1975.

Table 1
Demographic and Clinical Characteristics of
Acute Situational Maladjustment Patients
by Hospital Disposition Category

<u>Variable</u>	<u>RTD^a</u>		<u>NRTD^a</u>	
	<u>Mean</u>	<u>S.D.</u>	<u>Mean</u>	<u>S.D.</u>
Age	24.9	6.5	21.6	4.3
Length of service	6.2	6.1	2.6	4.0
Pay grade	4.1	1.6	2.9	1.4
General Classification Test	53.6	9.6	53.1	10.3
Days hospitalized	14.4	20.0	19.0	29.6
Number of cases	1874		204	

^aRTD - Returned to duty; NRTD - Not returned to duty.

Table 2
Correlations of Selected Predictor Variables with
Return to Duty and Effectiveness Criteria^a

	<u>Criteria</u>	
	<u>RTD</u>	<u>Effective</u>
<u>Demographic and Military Status Variables:</u>		
Pay grade (rank)	.26	.15
Job specialty ^b	.23	.14
Duty station ^b	.21	.14
Length of service	.20	.12
Age	.18	.13
Marital status (married)	.14	.08
General Classification Test (GCT)	.05	.07
<u>Clinical Variables:</u>		
Number of diagnoses (one)	.13	.02
Hospital days	.06	.02
Existed prior to enlistment (no)	.06	.02
Limited duty (no)	-	.08
Number of cases	2078	1874

^a All values greater than .02 are significant ($p < .05$).

^b Categories are grouped by criterion values.

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Behavior Disorder, suggesting that these underlying personality disturbances were undetected during the first hospitalization.

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